Society Proceedings.

NEW YORK NEUROLOGICAL SOCIETY.

Stated Meeting, April 5th, 1887.

The President, C. L. DANA, M.D., *in the Chair.*

REPORT OF A CASE OF SARCOMA OF THE OCCIPITAL LOBE, CAUSING HEMIANOPSIA, REMOVED BY OPERATION.

By DR. W. R. BIRDSALL and DR. R. F. WEIR.[1]

REPORT OF A CASE OF CYST OF THE BRAIN, WITH OPERATION.

DR. GRAEME M. HAMMOND related the case. The patient, a married woman, complained of severe pain an inch above the right ear, and had left hemiplegia. At the time her symptoms began, she was about twenty-nine years of age; she had had four children. During the progress of her disease she had a fifth child. All were strong and well. Her sickness lasted about two years and a half. It commenced by sudden loss of consciousness and convulsion limited to the left side. The left side of the face became, and remained, paralyzed. About a year later she noticed gradual loss of power in the left arm; things dropped from the hand. At the end of another year, the left arm was completely paralyzed. She then noticed increasing weakness in the left leg. When Dr. Hammond first saw her, she was able to stand and walk slowly. While the paralysis was extending, she had four or five epileptic seizures, confined to the left side. Headache developed about the time the legs became affected, grew more constant, and was described as agonizing.

She denied syphilis. Physical examination showed loss of motion on the left side of the face, tongue, and soft velum; of the left arm, and partial loss of motion in the left leg. There was no

[1] See this JOURNAL for May, 1887.

disturbance of sensibility of any kind. The reflexes were exaggerated on both sides. Sight, hearing, smell, and taste were normal. Choked disc on both sides was observed at a subsequent examination.

Under treatment, the headache was controlled to a considerable extent. Dr. Hammond's diagnosis was probable cerebral tumor, involving the cortical or subcortical substance of the motor centres. An operation was refused. The patient grew worse until the 20th of March, 1887, when her husband asked that the operation be performed. Dr. Spitzka then saw the patient with him, and made two examinations. He rather coincided in the diagnosis. The operation was performed in the hospital last Wednesday. Dr. M. Josiah Roberts assisted at the operation, removing the portion of skull by his electro-osteotome. Four buttons were removed by the electro-trephine; they were connected by straight lines made with the circular saw. The diameter of the opening was over two inches. A crucial incision was made through the dura. A hypodermic needle was introduced in different directions, but no fluid was withdrawn. The dura was closed. A drainage-tube was introduced, the skin flaps were sewed up, the patient was put to bed. She lived only twenty-one hours, remaining unconscious after the operation. Prior to the operation, she had become completely paralyzed in the left lower limb; she had delusions and hallucinations; she talked incoherently; bed-sores developed.

The autopsy showed little hernial protrusion at the wound; the cortical substance here was thin. Incision through the motor region revealed three cysts in a line, deep in the white substance. The fluid in the cysts has been only partially examined: it was serum, and contained broken-down brain substance. The cysts were close together, and in a position to affect the face, arm, and leg centres. He could not explain why the syringe failed to bring forth fluid, unless it was that the cysts were too deeply situated or the needle passed between them. He added to the clinical history that the head was drawn to the right side the last three days of life.

DISCUSSION.

DR. E. C. SEGUIN was partly responsible for the operation in the first case, but it seemed the patient would not live more than two or three months without it. He expected to find a large tumor, but was somewhat surprised to see it encapsulated and non-parenchymatous. During the early history of the case the

symptoms pointed to destruction of brain tissue. He asked Dr. Hammond whether the sensory or motor symptoms determined the seat of his operation.

DR. HAMMOND replied that the headache corresponded to the centre for the motor symptoms and the seat of the operation.

DR. SEGUIN added that the seat of pain would be a very uncertain indication for the seat of the operation. In some cases of cerebellar tumor, for instance, the pain had been mostly frontal.

DR. E. C. SPITZKA, referring to the case reported by Dr. Birdsall and Dr. Weir, said that an artery, large enough to cause fatal hemorrhage, entered the gray and white substance of the right occipital lobe. It had been overlooked in many text-books.

DR. ROBERTS explained how the circular saw could be used without injury to the brain; and the operation of the electro-osteotome.

DR. STARR suggested the desirability of an analysis of reported cases of cerebral tumors for the purpose of determining their rapidity of growth and size.

DR. R. L. PARSONS read a paper entitled:

NOMENCLATURE IN PSYCHIATRY. MONOMANIA OR OLIGOMANIA, WHICH? PARANOIA, WHAT? (See this JOURNAL, April, 1887.)

Stated Meeting, May 3d, 1887.

CHARLES L. DANA, M.D., *President, in the Chair.*

The election of officers for the ensuing year resulted as follows:

For President, C. L. Dana, M.D.; for first Vice-President, W. R. Birdsall, M.D.; for second Vice-President, M. A. Starr, M.D.; for Recording Secretary, G. W. Jacoby, M.D.; for Corresponding Secretary, W. M. Leszynsky, M.D.; for Treasurer, E. C. Harwood, M.D.; for Councillors, E. D. Fisher, M.D., B. Sachs, M.D., L. Weber, M.D., E. C. Seguin, M.D., and G. M. Hammond, M.D.

NOMENCLATURE IN PSYCHIATRY. MONOMANIA OR OLIGOMANIA, WHICH? PARANOIA, WHAT?

The discussion of this paper by DR. R. L. PARSONS, read at the last meeting of the Society, was taken up.

DR. KELLOGG said he was not well informed of the contents of Dr. Parson's paper, but he would say that it seemed to him the term monomania had come into so general use in literature

both medical and medico-legal, that it would be very difficult to get rid of it. It was very easy to use new terms, and perhaps etymologically they might be more appropriate than the old, but there was a practical use of the word monomania, and it was very difficult to find another which would fill its place. Monomania had been employed to indicate many different conditions of mental disease. If we could limit the clinical group of mental symptoms, we might then suggest more exact terms. There was a group of clinical symptoms associated with certain neuroses, such as epilepsy and chorea, also sometimes associated with toxic states, as in alcoholism, or with diathetic states, as syphilis or tuberculosis, which took the form of a fixed delusion. By some authors such symptoms had been classed under the term monomania. Other authors had applied this term to conditions of perverted emotions. What one term would better indicate all these conditions than the word monomania? He thought none. All that he could do would be to single out the several clinical groups of symptoms included under the term monomania, and apply to each group a distinct term. He thought, however, the generic term monomania would remain. At any rate, he could see no advantage in seeking for a term which would replace it. If Dr. Parsons wished to designate one distinct group of symptoms from among several which were now included in the term monomania, by the use of the term oligomania he might agree with him, but he did not think any advantage would be derived from substituting the latter term for the former.

DR. W. R. BIRDSALL had listened with interest to Dr. Parsons' paper on "Nomenclature in Psychiatry," because of the importance and difficulty of the subject, but the impression left upon his mind was that we were not much better off with the terms coined in recent times. He must certainly agree with the author regarding the indefiniteness with which the term monomania had been employed, but he agreed with Dr. Kellogg that in its generic sense it was pretty well understood. There was, however, a popular misconception regarding its meaning which he thought constituted a strong objection to its use. Dr. Birdsall had come to use the term paranoia as a substitute for that of monomania, with satisfaction to his own mind. The objection to it mentioned by Dr. Parsons, that it did not mean much if anything, in Dr. Birdsall's opinion constituted one of its merits. Monomania was so definite as to be liable to misconstruction. In reconstructing nomencla-

ture, he sometimes thought it was a misfortune that we could not fall back on Choctaw, instead of being compelled to resort to Greek or Latin. There was a certain disadvantage in having to resort to a compound word to express a group of symptoms or type of disease; it often failed to describe anything clearly. He believed, with Dr. Kellogg, that unless the symptoms included in the general term monomania were subdivided into groups, and an appropriate term for each group was found, little advantage would be derived by substituting a single new term.

DR. B. SACHS objected to the term monomania for two reasons: first, its etymological meaning was different from its accepted meaning in the nomenclature of psychiatry; second, in accepting its use, we implied our approval of the old division into *monomanias*, and thus lost sight of the true character of serious mental troubles. He thought the term oligomania was less objectionable than that of monomania, but he did not believe there was any absolute need of either term at the present time. He had not been compelled to make a diagnosis of monomania for several years. In general, he agreed with Dr. Birdsall's remarks on paranoia, but he thought also that the term primary insanity would be little liable to misconstruction, and might on some grounds be preferred either to paranoia or monomania. He would be in favor of using the term paranoia or primary insanity with such qualifying phrase as to the character of delusions, etc., as might be necessary in different cases.

THE PRESIDENT thought Dr. Parsons deserved credit for his paper, as there was certainly need of improvement in our nomenclature. If the paper had been read five years ago, the term oligomania would probably have stood a better chance for adoption. But it had now become fashionable to use the term paranoia, and he, like Dr. Birdsall, felt a certain amount of mental satisfaction in its use. He had some time since come to the conclusion that any attempt to reform nomenclature, if by a single individual, would be utterly useless. Such questions must be referred to conventions. One man could do nothing unless he discovered some fundamental principle on which to base a nomenclature which would prove superior to that now in use.

DR. PARSONS thanked the members for the adverse as well as the favorable criticisms of his paper, and in reply repeated certain statements made in his paper. He did not believe that any convention of men could alter a nomenclature. Whether or not a

given term would be adopted depended much upon accidental circumstances. He looked for advances in nomenclature rather from individual effort. He had not found it necessary to use the term monomania; the term partial insanity was more applicable in many cases.

CASE OF SUPPOSED CEREBRAL TUMOR—PARTIAL REMOVAL.

DR. S. N. LEO read the history of a case of cerebral tumor occurring in a heavy German woman who had before its appearance sustained an injury of the skull where the tumor afterward developed. During the growth of the tumor, the patient had consulted several well-known physicians, all of whom were of the opinion that an operation should be performed. Some thought it was a wen of the scalp. The symptoms becoming more serious, she finally asked Dr. Leo to perform the operation. He was assisted by Dr. Harwood and Dr. Guleke. Strict antisepsis was observed. As the operation proceeded, it was found that the tumor extended within the cranium, involving the dura mater at the longitudinal sinus, and apparently dipping deeply into the brain substance. These facts, in addition to the patient's bad condition from loss of blood, led him to desist from further procedure after cutting off that portion of the tumor external to the cranial vault. He thought the patient would not have lived so long (over a month), had not the operation been performed. Unfortunately, an autopsy was not allowed. The tumor was a sarcoma. He added that the patient's condition had been rendered more serious by cardiac disease.

DR. L. WEBER regretted that the title of the paper on the cards of announcement had been "Report of a Case of Cerebral Tumor Successfully Removed." He also regretted that there had not been a post-mortem examination.

DR. B. SACHS then read a paper entitled:

NOTES ON THE CAUSE AND TREATMENT OF FUNCTIONAL INSOMNIA.

Under this term he included cases of insomnia, pure and simple occurring in persons of the neurasthenic habit. He preferred to say neurasthenic rather than hysterical, for in his experience actual insomnia is less frequent in truly hysterical patients than in those suffering from cerebral or spinal neurasthenia. A number of typical cases were given. In attempting to explain

these cases, and work done by physiologists on this head, the reader concluded that in the majority of cases we had good evidence of disturbances in cerebral circulation. And as Mosso had found in animals that increased activity of cerebral circulation was accompanied by deficient circulation in the peripheral organs, so in many cases of chronic insomnia, cold extremities, pallor of the skin, scanty uterine flow pointed to deficient peripheral circulation, and in many of these cases there were weak heart and weak pulse. Special attention was called to the simultaneous occurrence of insomnia and headache, and that in these cases the headache was, as a rule, of the *paralytic* migraine type. Cases were quoted in evidence.

The treatment in cases of migraine and insomnia was similar in many respects, and proved effectual in both conditions.

As regards treatment, the point the author of the paper wished particularly to insist on was that continued hypnotic medication was worse than useless; that the good results obtained by him were due to close attention paid to matters of general *régime;* to the treatment of an existing anæmia; to the strengthening of the force of the heart's action by cold douches, by the regulation of exercise, and the methodical performance of definite forms of active physical exercise, such as riding, rowing, and mountain climbing. Hypnotics were of use only at the outset of treatment; among these the reader recommended chloral and bromides to be given at night, the bromides alone, amorphous hyoscyamia, urethan (2.0), and paraldehyde (4.0–6.0 in wine); but that these hypnotics were to be withdrawn as soon as a slight improvement in sleep was noticeable, and from that time onward general treatment was to be pushed vigorously.

Dr. Fisher thought a very common cause of insomnia was anæmia, and he had seen considerable success in its treatment by cod-liver oil, cream, and articles intended to improve nutrition. In some of the cases, ordinary hypnotics had been administered without any avail. The patients might have the appearance of being well nourished while they were really anæmic. The mineral tonics were, as a rule, indicated.

Dr. George W. Jacoby thought the paper was an exceedingly important one, especially in that it called attention to the fact that many cases of insomnia could be cured by rational measures alone, without the use of any medicines whatever. He agreed with the author that the cases must be individualized, and thus

the cause of the wakefulness might be discovered. He thought that in the majority of cases the cause would be found to lie in the circulation; not always in anæmia, but frequently hyperæmia. Cure the cause and we would cure the sleeplessness. But that which would cure anæmia in one case would not cure it in another. Active and passive exercise, particularly active exercise, were of benefit. For patients who could not go out, the muscle beater was very useful. While he had not much faith in static electricity in the treatment of insomnia, he cited one case in particular in which the physician who applied it for another purpose to one of his patients himself became sleepy under its influence. Perhaps the production of ozone by the instrument was the cause of this sleepiness; for it was well known that when we went into an atmosphere of ozone we were likely to become sleepy.

DR. V. P. GIBNEY had noticed that static electricity tended to produce the sleep state. It was one of these things they had found static electricity good for at the hospital with which he was formerly connected.

DR. W. R. BIRDSALL thought, as did Dr. Sachs, that we must adopt hygienic rather than purely medicinal measures for the cure of insomnia, but we were occasionally forced, as the author had said, to resort to some drug for temporary relief. For this purpose he had obtained benefit without injurious effects, such as sometimes came from bromide, hydrate of chloral, etc., from a drug first recommended to him by Dr. Seguin, namely, conium. This given in large doses, fifteen or twenty drops or more of the fluid extract, had in his hands been beneficial. He had continued its use two or three months without deleterious results.

DR. G. M. HAMMOND thought fully eighty per cent of all his patients were similar to those described in the paper by Dr. Sachs—persons suffering from insomnia, mental anxiety, etc. In the large majority of the cases, he thought it was due to hyperæmia of more or less limited areas of the brain. When the patients did sleep, they had unpleasant dreams. They were also frequently sufferers from dyspepsia, constipation, spots before the eyes, noises in the ears, sometimes hallucinations connected with various senses, and coldness of the extremities. It was rare for such patients to go away without being cured, but if they subjected themselves to the same causes, the condition returned. He used bromides, and stuck to them right through the disease. He gave only ten or fifteen grains three times a day, and also gave fluid extract of ergot. He

applied static electricity and dry cups to the back of the neck, and regulated the sleeping hours.

DR. LESZYNSKY was rather surprised, in view of a recent discussion before the Society, to hear Dr. Sachs speak of the use of hyoscyamine as a hypnotic. It was a mistake to rely upon large doses of bromides given at night. There was an objection to their use in ladies, because of the bad odor which they gave the breath. He had not been able to discover any peculiarity in the circulation of the retina in these cases.

DR. L. WEBER said that since he had adopted the treatment recommended by Dr. W. A. Hammond, and just described by Dr G. M. Hammond, he had obtained the best results in suitable cases for this mode of treatment. But in other cases the bromides might cause excitement instead of aiding sleep. When there was gastro-intestinal disorder, he added to the treatment calomel with benefit.

DR. LESZYNSKY referred to a remark by Dr. Birdsall concerning the use of a mustard sinapism, or other cutaneous irritant, and says that Dr. W. H. Thomson had called attention to the beneficial effects of Cayenne pepper, etc., to the surface of the body some years ago.

THE PRESIDENT had found the warm bath a very valuable measure in many cases ; in mild cases of insomnia the cold douche down the back and massage had proven useful. Binz had discovered that ozone has a hypnotic influence. Lupulin had been of benefit in the insomnia of old people, and lavender in some cases in which the stimulus of alcohol or warm food had failed.

DR. SACHS objected to the use of bromides, particularly in small doses, more than to anything else in the treatment of the class of cases under discussion, namely, those of insomnia in neurasthenic subjects. It was likely to do more harm than good. The testimony at the discussion referred to by Dr. Leszynsky was not against amorphous hyoscymia, but against the crystalline form.

THE PRESIDENT exhibited

AN APPARATUS FOR THE RELIEF OF WRITER'S CRAMP,

called the "Kaligraph" by its inventor, the late Mr. Charles Thurber. It consisted of an iron framework, to which was attached a series of levers so arranged that by making large characters at one angle the characters were reproduced in ordinary size at the opposite angle. It was, in fact, a kind of reversed panta-

graph. Dr. Dana said that all writer's-cramp instruments were based on the principle of resting the groups of muscles most used and throwing the work upon other groups. The kaligraph fulfilled these indications better than any other instrument with which he was familiar. The objections to it were that it was cumbersome and expensive. The speaker showed cuts of all the various forms of instruments for writer's cramp (10 in all) which he had been able to collect. The kaligraph had been in practical use for thirty years, but it was very little known. It had enabled its inventor, who suffered extremely from the cramp, to write with comfort. He was informed that Charles Dickens had possessed and used one.

DR. G. W. JACOBY thought this instrument was only palliative while Nussbaum's was also curative, and could be carried with one. It compelled the writer to use the abductors.

THE PRESIDENT replied that an instrument calling into play another group of muscles of the hand would cause those to be affected after a time.

DR. BIRDSALL thought writer's cramp was due to cerebral fatigue rather than to muscular fatigue, and that instruments for overcoming it could be of only limited benefit.